MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9599

CERTIFICATE OF DEATH

Reg. Dist. No. 09602

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6month 29days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (14) 3V01.4
STREET ADDRESS (If rural give location) 5106 Richard Avenue

3. NAME OF DECEASED: (First) LILLIE (Middle) BLANCHE (Last) ALBERT
4. DATE OF DEATH: (Month) October (Day) 27 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2-12-77
9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank M. Sturgeon
14. MOTHER'S MAIDEN NAME: Martha Underwood Sturgeon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO

ANTECEDENT CAUSE (B) Arteriosclerotic Heart Disease — Years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain dis., 6½Yr.+ with psychotic reaction.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Hospital
21C. WHERE DID INJURY OCCUR? (City or town) Sykesville (County) Carroll (State) Md.
21D. TIME OF INJURY (Month) 7 (Day) 24 (Year) 55 (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☒
21F. HOW DID INJURY OCCUR? Pt. Accidently slipped on floor.

22. I hereby certify that I attended the deceased from 9-10, 1955, to 10-27, 1955, that I last saw the deceased alive on 10-26, 1955, and that death occurred at 4:25AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustbader M. D. ADDRESS Springfield State Hospital DATE SIGNED 10-27-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-31-55
NAME OF CEMETERY OR ~~CREMATORY~~ Greenmount
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 28, 1955
REGISTRAR'S SIGNATURE C. Henry Uhler
24. FUNERAL DIRECTOR H. Sander's Son - North & Broadway. ADDRESS

RECEIVED
OCT 31 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09603

9600 CERTIFICATE OF DEATH Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithers
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithers
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) James (Last) Anthony

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 5, 1904

9. AGE last birthday: 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Male Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Springfield Hospital

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John J. Anthony

14. MOTHER'S MAIDEN NAME: Mary C. Cullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) -

16. SOCIAL SECURITY No.: 212-03-2988

17. INFORMANT & ADDRESS: Mrs Agnes Anthony - Gaithers, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
153X
Immediate cause (a) Cardiac Arrest, Coronary Occ — Interval Between Onset And Death: Sept 55 to Oct 55
DUE TO
Antecedent causes (b) Generalized Arteriosclerosis - Cerebral
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) Arteriosclerosis.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1955, to Oct 21, 1955, that I last saw the deceased alive on 21 Oct., 1955, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Howard E Hall MD ADDRESS Sykesville DATE SIGNED 21 Oct 55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 10-24-55 NAME OF CEMETERY OR ~~CREMATORY~~ Springfield LOCATION (City, town, or county) (State) Sykesville, Carroll, Md

DATE REC'D BY LOCAL REGISTRAR Oct 24, 1955 REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Luther W Haight ADDRESS Sykesville, Md.

VS. A15

RECEIVED
OCT 25 1965
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9601

CERTIFICATE OF DEATH

09604

Reg. Dist. No. 2E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural Westminster
LENGTH OF STAY (in this place): 5 0 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: OO Spring Mills

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster X
STREET ADDRESS (If rural, give location): Spring Mills 1

3. NAME OF DECEASED: (Type or Print) (First) LAURA (Middle) C. (Last) BABYLON

4. DATE OF DEATH: (Month) Oct. (Day) 2 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: August 19-1877

9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Christopher Shickles

14. MOTHER'S MAIDEN NAME: Ellen Stonesifer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Earl Babylon Spring mills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 592 X — (a) Central Hemorrhage — Interval Between Onset And Death: 1 day

Antecedent causes (b, c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (a) Myocarditis (chr.) — DUE TO (b) Hypertension (chr.)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1930, to 10-2-, 1955, that I last saw the deceased alive on 10-2, 1955, and that death occurred at 10.45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. C. Jeannette M.D. — ADDRESS: 103 E Main Westminster — DATE SIGNED: 10-3-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 6, 1955 — NAME OF CEMETERY OR CREMATORY: Meadows Branch Cemetery — LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: 10-3-55 — REGISTRAR'S SIGNATURE: Hamil Miller — 24. FUNERAL DIRECTOR: H. Bankard Son — ADDRESS: Westminster, Md.

Dr Jeannette

VS. A15

RECEIVED
OCT 4 1965
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09605

9692 CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: X rural Westminster
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 08 R. 6

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Westminster X
STREET ADDRESS (If rural give location): R. 6 1

3. NAME OF DECEASED (Type or Print): (First) Madie (Middle) Jane (Last) Bollinger

4. DATE OF DEATH: (Month) Oct. (Day) 14 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 29, 1876

9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Arnold

14. MOTHER'S MAIDEN NAME: Mary Grimes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service): - - - - -

16. SOCIAL SECURITY NO.: - - - - - - -

17. INFORMANT & ADDRESS: Hayden C. Bollinger R 6 Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 4 days.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerosis with Hypertension — years.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 10 1955, to Oct. 14, 1955, that I last saw the deceased alive on Oct 12 1955, and that death occurred at 11 30 a.m. from the causes and on the date stated above.

SIGNATURE: James I. Mench — (Degree or title) M.D. — ADDRESS: Westminster Md — DATE SIGNED: 10/14/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 17, 1955 — NAME OF CEMETERY OR CREMATORY: Deer Park — LOCATION (City, town, or county) (State): Smallwood Maryland

DATE REC'D BY LOCAL REGISTRAR: Oct 18 1955 — REGISTRAR'S SIGNATURE: Harold Miller

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

VS. A15

RECEIVED
OCT 18 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09606

9603 CERTIFICATE OF DEATH Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 6 Smallwood

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
STREET ADDRESS (If rural give location) R 6 Smallwood

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) Ellen (Last) Bowers

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 1, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph E. Hess

14. MOTHER'S MAIDEN NAME: Belinda Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY No.: - - - - - - -

17. INFORMANT & ADDRESS: Mrs. C. Albert Frick 6 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a) acute cardiac Decompensation — Interval Between Onset And Death: 1-5 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Cerebral Hemorrhage — 4 days

DUE TO (c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2, 1955, to 10-6, 1955, that I last saw the deceased alive on 10-5, 1955, and that death occurred at 7.25 A.M. from the causes and on the date stated above.

SIGNATURE Chas R Fouty (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 10.6.55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 8, 1955 NAME OF CEMETERY OR CREMATORY Deer Park LOCATION (City, town, or county) (State) Samllwood Maryland

DATE REC'D BY LOCAL REGISTRAR 10-7-55 REGISTRAR'S SIGNATURE Harriet Chandler

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 10 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9604

CERTIFICATE OF DEATH

09607

Reg. Dist. No. 94

1. PLACE OF DEATH
COUNTY Carroll (1) MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS (15) Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington (15-2)
STREET ADDRESS (If rural give location) 1502 Woodfield Road ✓

3. NAME OF DECEASED. (Type or Print) (First) MARGARET (Middle) O. (Last) BRIDEN

4. DATE OF DEATH: (Month) 10 (Day) 5 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH: 12/27/76
9. AGE last birthday 78 yrs
IF UNDER 1 YEAR: Months 5 Days 8
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Lang
14. MOTHER'S MAIDEN NAME: Margaret Osborne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
IMMEDIATE CAUSE (A) Acute Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Hours
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) General Arteriosclerosis — Years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease, with psychotic reaction 5 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (City or town) Kensington (County) Montgomery (State) Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-27-55 M.
21E. INJURY OCCURRED While at work [ ] Not while at work [X]
21F. HOW DID INJURY OCCUR? Unknown

22. I hereby certify that I attended the deceased from 9/8, 19 55 to 10/5, 19 55 that I last saw the deceased alive on 10/1, 19 55, and that death occurred at 8:30 A.M. est, from the causes and on the date stated above.

SIGNATURE Edward Surkness M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 10-10-55 — NAME OF CEMETERY OR CREMATORY Roschessic Cemetery — LOCATION (City, town, or county) Providence, County (State) R.I.

DATE REC'D BY LOCAL REGISTRAR Oct. 6, 1955 — REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR Robert A. Pumphrey — ADDRESS Inc. Pittsville

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

9605

09608

CERTIFICATE OF DEATH

Reg. Dist. No. 21

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR X TOWN Westminster
LENGTH OF STAY (in this place) 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS OD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print): (First) Ann — (Middle) E. — (Last) Null
4. DATE OF DEATH: (Month) Oct — (Day) 24 — (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 7-6-1874
9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial (chr) Hypertn (chr)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral hemorrhage

(c)

INTERVAL BETWEEN ONSET AND DEATH: Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1940, to Oct 24, 1955, that I last saw the deceased alive on Oct 22, 1955, and that death occurred at 3.30 A m., from the causes and on the date stated above.

SIGNATURE: H C Jennie M.D. (Degree or title) — ADDRESS: Westminster Md — DATE SIGNED: Oct-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 10-27-55 — NAME OF CEMETERY OR CREMATORY: [illegible] — LOCATION (City, town, or county) (State): [illegible]

DATE REC'D BY LOCAL REG. 10/25/55 — REGISTRAR'S SIGNATURE: Margaret R. Englar

24. FUNERAL DIRECTOR — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09609

9616

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 42 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfiel d State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ???? ICX-2
STREET ADDRESS (If rural give location) ????

3. NAME OF DECEASED: (Type or Print) (First) Betts (Middle) —— (Last) Butts

4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): ???

8. DATE OF BIRTH: about 1871

9. AGE last birthday: ? 84 ? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ????

10B. KIND OF BUSINESS OR INDUSTRY: ????

11. BIRTHPLACE (State or foreign country): ????

12. CITIZEN OF WHAT COUNTRY? ????

13. FATHER'S NAME: ????

14. MOTHER'S MAIDEN NAME: ????

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ???? (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ????

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary occlusion — minutes
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia, hebephr. type — more than 42 yrs

19A. DATE OF OPERATION: ——
19B. MAJOR FINDINGS OF OPERATION ——
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ——
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ——
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY —— M
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from Spt. 1, 1947, to Oct. 17, 1955, that I last saw the deceased alive on Oct. 16, 1955, and that death occurred at 6:00 AM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. M.D. — ADDRESS Sykesville, Md — DATE SIGNED Oct. 17, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL — DATE THEREOF OCT 17 1955 — NAME OF CEMETERY OR CREMATORY U OF M MEDICAL SCHOOL — LOCATION (City, town, or county) 295 GREEN ST (State) MD.

DATE REC'D BY LOCAL REGISTRAR Oct. 18, 1955 — REGISTRAR'S SIGNATURE C Harry Deer

24. FUNERAL DIRECTOR Duffield Bro — ADDRESS 1800 E LOMBARD ST.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09610

9607

CERTIFICATE OF DEATH

Reg. Dist. No. 7-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:
   COUNTY: Carroll
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Henryton
   LENGTH OF STAY (in this place): 415 Days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: 0.3 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland
   COUNTY:
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
   STREET ADDRESS (If rural give location): 530 Johannsen Street

3. NAME OF DECEASED: (Type or Print) (First) Norwood (Middle) (Last) Calloway

4. DATE OF DEATH: (Month) 10- (Day) 9- (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 5-30-1904

9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): New Orleans, Louisiana

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Samuel Calloway

14. MOTHER'S MAIDEN NAME: Arnita Gray

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 212- 20-7901

17. INFORMANT & ADDRESS: Norwood Calloway - 530 Johannsen Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 002X

(a) DUE TO: Far advanced bilateral pulmonary tuberculosis with cavitation

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO:

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20- ,1954 , to 10-9- , 19.55 , that I last saw the deceased alive on 10-9- , 1955 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.

SIGNATURE: I. F. Rodall M.D (Degree or title)

ADDRESS: Henryton, Maryland

DATE SIGNED: 10-9-55

23. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

DATE THEREOF: OCT 11 1955

NAME OF CEMETERY OR CREMATORY: U OF M MEDICAL SCHOOL

LOCATION (City, town, or county) (State): 29 S GREEN ST MD

DATE REC'D BY LOCAL REGISTRAR: 10-9-55

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Duffel Bro

ADDRESS: 1800 E LOMBARD ST

VS. A15

09611

MARYLAND

STATE DEPARTMETT OF HEALTH

9608 CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
MARYLAND
LENGTH OF STAY (In this place) 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) EDWARD (Last) COLSON

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 3-4-1908

9. AGE last birthday: 47 (47) yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B & O. R.R. Shops

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles O. Colson

14. MOTHER'S MAIDEN NAME: Mattie Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service) W.W.II

16. SOCIAL SECURITY NO.: 705-05-3371

17. INFORMANT AND ADDRESS: Ida May Crabb, Woodbine, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7544

Immediate cause (a) Cardiac arrest, Coronary thrombosis,

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congested heart disease, Cardiac edema.

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955, to 6 Oct, 1955, that I last saw the deceased alive on 6 Oct, 1955, and that death occurred at 5:30A m., from the causes and on the date stated above.

SIGNATURE Harold E Hall (Degree or title) MD ADDRESS Woodbine, Md. DATE SIGNED 6 Oct 55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE: 10-10-1955

NAME OF CEMETERY ~~OR CREMATORY~~: Morgan Chapel

LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REG.: Oct. 9, 1955

REGISTRAR'S SIGNATURE: Robert R. Hewitt, Dep.

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Maryland ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

9609 09612

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster, Md. LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sunnyside Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster
STREET ADDRESS (If rural, give location) Westminster RD #5

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) (Last) CONOVICH
4. DATE OF DEATH (Month) Oct (Day) 2 (Year) 1955

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH May 15, 1898 9. AGE last birthday 57 yrs. If under 1 year: Months Days. If under 24 hrs: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Oklahoma 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? 14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown 16. SOCIAL SECURITY NO. 216-10-5542 17. INFORMANT AND ADDRESS Mrs. Irma J. Conovich, Westminster, Md. RD#5

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

976X Immediate cause (a) Gunshot wound of head — minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) Westminster (COUNTY) Carroll (STATE) Md.
TIME OF INJURY (Month) Oct (Day) 2 (Year) 1955 (Hour) ? m. INJURY OCCURRED While at work ☐ Not while at work ☒ HOW DID INJURY OCCUR? self inflicted

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE [illegible] (Degree or title) Dep. Med. Examiner ADDRESS Westminster Md DATE SIGNED Oct 3/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 5, 1955 NAME OF CEMETERY OR CREMATORY Meadow Branch LOCATION (City, town, or county) (State) Rural, Westminster, Md.

DATE REC'D BY LOCAL REG. 10-3-55 REGISTRAR'S SIGNATURE Harriet [illegible] 24. FUNERAL DIRECTOR J. S. Myers, Jr. ADDRESS Westminster Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

09613

MARYLAND

STATE DEPARTMETT OF HEALTH

9610

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 6 yrs; 6 mon.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eldersburg.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
STREET ADDRESS (If rural, give location) Eldersburg.

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) Roth (Last) Currens

4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2-23-1884

9. AGE last birthday: 7/ yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Spring Grove Hospital

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Currens

14. MOTHER'S MAIDEN NAME: Amanda Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: Mrs Nettie Cunnan - Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Acute Coronary Thrombosis -

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Found dead on floor -

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/27/55, 19....., to 10/27/55, 19....., that I ~~last saw the~~ ded not see deceased alive on 10/27/55, 19....., and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE Lester Bowers (Degree or title) Deputy Coroner ADDRESS Westminster, Md. DATE SIGNED 10/27/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 10-29-55 | NAME OF CEMETERY OR CREMATORY: United Brethren | LOCATION (City, town, or county) (State): Thurmont, Md.

DATE REC'D BY LOCAL REG.: Oct. 28, 1955 | REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: Luther A. Haight ADDRESS: Sykesville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09614

9611 CERTIFICATE OF DEATH Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural- Sykesville
LENGTH OF STAY (in this place) 42 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Sykesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Chester (Middle) (Last) Davis

4. DATE OF DEATH: (Month) Oct. (Day) 12 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 12-16-1887

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY: general

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ira R. A. Davis Error

14. MOTHER'S MAIDEN NAME: Eva J. Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 219-12-1016

17. INFORMANT & ADDRESS: Mrs. Nina Davis, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cardio Vascular Disease

DUE TO (c)

Interval Between Onset And Death 18 hrs.

422.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/12/ ,1955, to 10/12/ ,1955, that I last saw the deceased alive on 10/12/ ,1955, and that death occurred at 1:05P:M, from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm E. Martin, M.D. ADDRESS Randallstown Md DATE SIGNED 10/13/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF 10-15-1955

NAME OF CEMETERY OR CREMATORY Winfield Church Of God

LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR Oct. 14, 1955

REGISTRAR'S SIGNATURE Robert P. Hewett.

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

VS. A15

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09615

9612

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural
LENGTH OF STAY (in this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead. Rural
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) ELLA (Middle) - M - (Last) DAWES

4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1955

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH: Nov 27-1878
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret
10B. KIND OF BUSINESS OR INDUSTRY: H.W.
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Rhodes
14. MOTHER'S MAIDEN NAME: Ella Ecklauf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No. ✓
17. INFORMANT & ADDRESS: Mrs Ethel White, Hampstead Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 447 IMMEDIATE CAUSE (A)	Cerebral Hemorrhage	2 hrs
ANTECEDENT CAUSE (B) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	Hypertensive C.V. Disease	15 yrs
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	old Cerebral Hemorrhage	7 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1948, to Oct 9, 1955, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 3 P M, from the causes and on the date stated above.

SIGNATURE M. C. Porterfield M. D. ADDRESS Hampstead, Md DATE SIGNED 10-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-12-1955
NAME OF CEMETERY OR CREMATORY St Paul's
LOCATION (City, town, or county) (State) Balto Co Md

DATE REC'D BY LOCAL REGISTRAR 10/9/55
REGISTRAR'S SIGNATURE Henry Rausch
24. FUNERAL DIRECTOR Edw. O. Tipton. ADDRESS Hampstead Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09616

9613 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural Westminster
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD. 5

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster X
STREET ADDRESS (If rural give location) R.D. 5 1

3. NAME OF DECEASED: (Type or Print) (First) ELIZA (Middle) ANNIE (Last) DAY

4. DATE OF DEATH: (Month) October (Day) 1 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 8, 1894

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John J. Edmundson

14. MOTHER'S MAIDEN NAME: Nancy Jane Parrish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: John E. Day R.D. 5 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 442X (a) Cardiac Decompensation — Interval Between Onset And Death: 15 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cardio-Renal disease — 2 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1955, to Oct. 1, 1955 that I last saw the deceased alive on Sept 30 1955 and that death occurred at 2 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Fout, M.D. ADDRESS Westminster, Md. DATE SIGNED Oct 3-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 4, 1955 NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery LOCATION (City, town, or county) Gamber (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-3-55 REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR A. Bankard & Son Westminster ADDRESS Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09617

9614 CERTIFICATE OF DEATH Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—1[illegible]-[illegible]

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1month 3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~City~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (4)
STREET ADDRESS (If rural give location) 510 Park venue

3. NAME OF DECEASED: (Type or Print) (First) HERMAN (Middle) GEORGE (Last) DOMNOSKY

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 11-25-80

9. AGE last birthday 74 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Veterinarian

10B. KIND OF BUSINESS OR INDUSTRY: Veterinary

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Ferdinand Domnosky

14. MOTHER'S MAIDEN NAME: Henrietta Domnoskey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Arteriosclerosis, general. — Years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CVS associated with senile brain dis., with psychotic reaction. — 1½ months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23, 1955, to 10-19, 1955, that I last saw the deceased alive on 10-19, 1955, and that death occurred at 8:40AM, from the causes and on the date stated above.

SIGNATURE Edmund Gusthaus M.D. ADDRESS Springfield State Hosp. DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-22-55 — NAME OF CEMETERY OR CREMATORY New Cathedral — LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 19, 1955 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR J. O. Mitchell & Sons. ADDRESS 1900 Eastern Ave.

09618

MARYLAND — **STATE DEPARTMETT OF HEALTH**

9615

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll, Sykesville, Maryland — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural: Sykesville, Md. — LENGTH OF STAY (in this place) 1 Mo. 6days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City — 13A-2
STREET ADDRESS (If rural, give location) Main Street

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Ridgely (Last) Dyson

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10-15-65

9. AGE last birthday: 90 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER (RET.)

10b. KIND OF BUSINESS OR INDUSTRY: FARM WORK

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Dyson

14. MOTHER'S MAIDEN NAME: Anna Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown/No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: - Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a). Coronary Occlusion — 5 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b). Generalized arteriosclerosis — years

(c).

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction — years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15 ..., 19 55, to 10-21 ..., 19 55, that I last saw the deceased alive on 10-21 ..., 19 55, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

SIGNATURE Gertrude M. Gross M.D. (Degree or title) — ADDRESS Springfield State Hosp. Sykesville, Maryland — DATE SIGNED 10-21-1955

23. BURIAL, CREMATION OR REMOVAL (Specify): BURIAL — DATE: 10/24/55. — NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEM. — LOCATION (City (town), or county) (State): HOWARD County, Md.

DATE REC'D BY LOCAL REG. Oct 21 1955 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR: Easton Sons — ADDRESS: Catonsville 28, Md.

MARGIN RESERVED FOR BINDING

9616 09619

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (In this place) 2month 28days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore (31) 3 1-4
STREET ADDRESS (If rural, give location) 1807 Bank Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	HENRY	EATON	OCTOBER	27	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Divorced	6-17-95	60 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farm work	Agriculture	Tennessee	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Samuel Eaton	Ellen Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	Unk -	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Embolism	Days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Bilateral Bronchopneumonia	5 days
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: CBS assoc. with diseases of unknown or unspecified cause with psychotic reaction. — 3yrs.+

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospital	21c. (City or town)	(County)	(State)
		Sykesville	Carroll	Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
10 14 55 9a. M.		Pt. fell in shower room - fractured hip

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE D. Matthew Barr M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 10/27/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Oct 28, 1955		FAIRFAX, VA.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 28, 1955	E. Harris Tilden	J. S. Everly	Fairfax, Va

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09620

9617

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 5/11/55
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ——
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1610 N. Calvert St.

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Williamson (Last) EDSON

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): unknown
8. DATE OF BIRTH: ~~unknown~~ 8-17-77
9. AGE last birthday 78 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——
10B. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): unknown Binghamton New York
12. CITIZEN OF WHAT COUNTRY? ~~unknown~~ U.S.

13. FATHER'S NAME: ~~unknown~~ William Edson
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ——
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis — more than 5 months

(C) DUE TO ——

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease — more than 5 mos.

19A. DATE OF OPERATION: ——
19B. MAJOR FINDINGS OF OPERATION ——
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 11, 19 55 to Oct. 19 1955, that I last saw the deceased alive on Oct. 19, 1955, and that death occurred at 7:18 P.M., from the causes and on the date stated above.

SIGNATURE Martin Brown M.D. M.D. ADDRESS Sykesville, Md. DATE SIGNED Oct 21-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/24/55
NAME OF CEMETERY OR CREMATORY St. Peters Cem.
LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR October 22. 1955
REGISTRAR'S SIGNATURE R.W
24. FUNERAL DIRECTOR Wm. J. Pickner & Sons
ADDRESS Balto 17 Md

9618

09621

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL MT AIRY
LENGTH OF STAY (in this place) 8 HRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) 337 S. STRICKER St

3. NAME OF DECEASED: (Type or Print) (First) AARON (Middle) (Last) EVANS
4. DATE OF DEATH (Month) Dec (Day) 6 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 12-11-73
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): MACHINIST NET
10b. KIND OF BUSINESS OR INDUSTRY: B&O. R.R.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hampton Evans
14. MOTHER'S MAIDEN NAME: Kate Barth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: A-R-B-A36718
17. INFORMANT & ADDRESS: NANCY JANE EVANS 337 S. STRICKER ST

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: minutes

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerosis — years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Pirrone M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 10/6/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF Oct 10-1955
NAME OF CEMETERY OR CREMATORY MORGAN CHAPEL CEM
LOCATION (City, town, or county) WOODBINE (State) Md

DATE REC'D BY LOCAL REG. 10-7-55
REGISTRAR'S SIGNATURE A. C. Fuss
24. FUNERAL DIRECTOR ADDRESS Pratt & Stricker Sts
Pratt & B. M. Walter

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09622

9619

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 6 Mos. 5 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 931 East 41st Street

3. NAME OF DECEASED: (Type or Print) (First) RUBY (Middle) B. (Last) GARDINER

4. DATE OF DEATH: (Month) 10 (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 3/27/85

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James P. Wakeland

14. MOTHER'S MAIDEN NAME: Hannah S. McFadden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

354 X

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 9 years?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21, 1955 to 10/6, 1955, that I last saw the deceased alive on 10/6, 1955, and that death occurred at 2 P EST M, from the causes and on the date stated above.

SIGNATURE Edmund Sutherland M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10/10/55 — NAME OF CEMETERY OR CREMATORY Cathedral — LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR October 8th 1955 — REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR MARTIN FAHEY & SONS — ADDRESS 401 SUFFOLK Rd.-18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620

CERTIFICATE OF DEATH

09623

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1yr.5mo.22days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (13) 3V01-4
STREET ADDRESS (If rural give location) 2715 Pelham Avenue

3. NAME OF DECEASED: (First) IDA (Middle) ANTOINETTE. (Last) GERNHART
4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	5-20-91	64 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS
10B. KIND OF BUSINESS OR INDUSTRY: H.BERLIN CLOTHING CO
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Knorr
14. MOTHER'S MAIDEN NAME: ANNA ERPENSTEIN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) NO.
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 X IMMEDIATE CAUSE	(A) Uremia	two weeks
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Chronic Glomerulonephritis	years
	(C) DUE TO Hypertensive cardiovascular disease	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with disturbance of metabolism, growth or nutrition, presenile brain dis., with psychotic reaction. 2yrs. +

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1- , 1955, to 10-28 , 1955, that I last saw the deceased alive on 10-27-55, 19 ... , and that death occurred at 8:22AM, from the causes and on the date stated above.

SIGNATURE Walther H. Schmidt M.D. ADDRESS Springfield State Hosp. DATE SIGNED 10-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 31,1955	Holy Redeemer Cemetery	Belair Rd.

DATE REC'D BY LOCAL REGISTRAR 10/31/55
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 2601-03-05 E. Madison Street

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09625

9596 # CERTIFICATE OF DEATH Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 263 E. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural give location) 263 E. Main 1

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) LESTER (Last) GUIDER
4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	June 25-1887	68 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, (even if retired): Cleaner & Dyer
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George C. Guider
14. MOTHER'S MAIDEN NAME: Kate Wheat

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) WW. I
16. SOCIAL SECURITY NO.: 213-09-8165
17. INFORMANT & ADDRESS: Mrs J.B. POTTORF Hottenville, Ky.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 421.0 (a) Cardiac decompensation
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Mitral insufficiency
DUE TO
(c)

Interval Between Onset And Death: 10 days / 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1954, to Oct 9, 1955, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 10:35 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title) Julian Chenko M.D. ADDRESS 130 E Green, Westminster Md DATE SIGNED 10/11/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 12, 1955 NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery LOCATION (City, town, or county) Mt Wilson (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-11-55 REGISTRAR'S SIGNATURE Hazel Carter
24. FUNERAL DIRECTOR Hilbert & Hilbert ADDRESS Westminster Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9622 09626

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (In this place) since 5/14/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brunswick 10-35-2
STREET ADDRESS (If rural give location) 3 West "C" Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Henry (Last) HAHN

4. DATE OF DEATH: (Month) (Day) (Year) October 24 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower

8. DATE OF BIRTH: October 11, 1855

9. AGE last birthday: 100 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10B. KIND OF BUSINESS OR INDUSTRY: ——Unk——

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ——

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 450.0

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Generalized arteriosclerosis — about 2 yrs.

DUE TO (C) ——

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease — about 2 yrs.

19A. DATE OF OPERATION: ——

19B. MAJOR FINDINGS OF OPERATION: ——

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ——

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ——

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ——

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ ——

21F. HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from May 29, 1954 to Oct. 24, 1955, that I last saw the deceased alive on Oct. 24, 1955, and that death occurred at 3:40P M, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. ADDRESS Sykesville, Md. DATE SIGNED 10/24/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10-27-55 | NAME OF CEMETERY OR CREMATORY Park Heights | LOCATION (City, town, or county) (State) Brunswick, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 25, 1955 | REGISTRAR'S SIGNATURE C. Harry Giles

24. FUNERAL DIRECTOR C. A. Fink & Son ADDRESS Brunswick, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9623 **CERTIFICATE OF DEATH** 09629

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH. COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balto. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City #6
STREET ADDRESS (If rural give location) 2400 Bowley's Lane

3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) Elizabeth (Last) HALL

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: Fe | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widow | 8. DATE OF BIRTH. 5-24-99 | 9. AGE (last birthday) 56 yrs. | IF UNDER 1 YEAR: Months 4 Days 28 | IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Chester | 14. MOTHER'S MAIDEN NAME: Sadie Diamond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 219-16-8784 | 17. INFORMANT & ADDRESS: Ruth Huth (daughter) 2400 Bowley's Lane, Balto, 6

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

321X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage sec — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S): DUE TO Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO and Hypertension — 4 yrs

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with Arteriosclerosis

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 1955 to 10-22, 1955 that I last saw the deceased alive on 10-22, 1955, and that death occurred at 10:35 PM from the causes and on the date stated above.

SIGNATURE Walther H. Longcope Jr. M.D. ADDRESS Springfield State Hospital DATE SIGNED 10/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 10-26-55 | NAME OF CEMETERY OR CREMATORY OAK LAWN CEM | LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.

DATE REC'D BY LOCAL REGISTRAR 10/25/55 | REGISTRAR'S SIGNATURE C. W. Heckrotte | 24. FUNERAL DIRECTOR Lorraine Sinclair | ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09627

9624 CERTIFICATE OF DEATH Reg. Dist. No. 7H

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1 PLACE OF DEATH

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Sykesville

LENGTH OF STAY (in this place) 25 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (2) 3Y01-4

STREET ADDRESS (If rural give location) 514 East Pratt Street

3. NAME OF DECEASED: (Type or Print) (First) NELSON (Middle) CROMWELL (Last) HAM

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1955

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.

8. DATE OF BIRTH 8-3-19

9. AGE last birthday 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel clerk

10B KIND OF BUSINESS OR INDUSTRY: Hotels

11 BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William Henry Ham

14. MOTHER'S MAIDEN NAME. Maude Elizabeth ? ? ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS. Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.1

IMMEDIATE CAUSE (A) Hepato-renal syndrome — several days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) liver cirrhosis — not known

DUE TO

(C) chronic Alcoholism — 4 years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with alcohol intoxication, with psychotic reaction. — Years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1955, to 10/12/, 1955, that I last saw the deceased alive on 10/12/, 1955, and that death occurred at 11:10 PM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 10/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 10-17-55

NAME OF CEMETERY OR CREMATORY Staunton

LOCATION (City, town, or county) Staunton (State) Va.

DATE REC'D BY LOCAL REGISTRAR 10-14-1955

REGISTRAR'S SIGNATURE E. Wally Tyler

24 FUNERAL DIRECTOR Julia N. Haight

ADDRESS Staunton Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9597 **CERTIFICATE OF DEATH** Reg. Dist. No. 09628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster
LENGTH OF STAY (in this place) 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Anita Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 10 Anita Drive

3. NAME OF DECEASED: (First) MARGARET (Middle) MERRITT (Last) HAMILL
4. DATE OF DEATH: (Month) (Day) (Year) Oct 14 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	Jan. 12, 1911	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ethington Merritt
14. MOTHER'S MAIDEN NAME: Annie Pohler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service)
17. INFORMANT & ADDRESS: Mr. Leslie W. Hamill, 10 Anita Dr. Westminster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
175X
Immediate cause (a) Carcinoma Ovary. — Interval Between Onset and Death: 2 years
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov 11 1953
19b. MAJOR FINDINGS OF OPERATION: Carcinoma Ovary
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1955, to Oct 14, 1955, that I last saw the deceased alive on Oct 13, 1955, and that death occurred at 3:25 p.m., from the causes and on the date stated above.
SIGNATURE James J. Marsh (DEGREE OR TITLE) M.D. ADDRESS Westminster Md DATE SIGNED Oct 14-1955

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Oct. 18, 1955
NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REG. 10-17-55
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road #14

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09630

9625 CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): X Henryton
LENGTH OF STAY (in this place): 5 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 551 Orchard Street

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) P. (Last) Harris

4. DATE OF DEATH: (Month) 10- (Day) 4- (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 8-9-1900

9. AGE Last birthday: 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Fletcher Tyler

14. MOTHER'S MAIDEN NAME: ???? Parker

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Daisy P. Harris - 551 Orchard Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 0093X
(a) DUE TO: Far advanced bilateral pulmonary tuberculosis with cavitation

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: Cardiovascular disease
(c)

Interval Between Onset And Death:

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-29-, 1955, to 10-4-, 1955, that I last saw the deceased alive on 10-4-, 1955, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): T. F. Postal, M.D
ADDRESS:
DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
DATE THEREOF: OCT 10 1955
NAME OF CEMETERY OR CREMATORY: U of M MEDICAL SCHOOL
LOCATION (City, town, or county) (State): 295 GREENE ST MD
ADDRESS:
DATE REC'D BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: Duffy Bros. 1800 E LOMBARD ST.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09631

9626

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. X
LENGTH OF STAY (in this place) 53 y
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: Md. STATE COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Johanna (Middle) (Last) HESSLER

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday 87 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S): DUE TO (B) Hypertensive Cardio-Vascular

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Desease

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1912, to 10-8, 1955, that I last saw the deceased alive on 10-7, 1955, and that death occurred at 640 A.M, from the causes and on the date stated above.

SIGNATURE A. Leibigha M.D. ADDRESS Springfield Md. DATE SIGNED 10/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | DATE THEREOF OCT 17 1955 | NAME OF CEMETERY OR CREMATORY U OF M MEDICAL SCHOOL | LOCATION (City, town, or county) 29 S GREEN ST (State) MD

DATE REC'D BY LOCAL REGISTRAR Oct. 18, 1955 | REGISTRAR'S SIGNATURE C. Harry Thorp

24. FUNERAL DIRECTOR Diffel Bros. ADDRESS 1800 E LOMBARD ST

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9527

CERTIFICATE OF DEATH

09632

Reg. Dist. No. 74

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Henryton

LENGTH OF STAY (in this place): 16 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY:

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

STREET ADDRESS (If rural give location): 1321 Presstman Street

3. NAME OF DECEASED (Type or Print): (First) Mabel (Middle) (Last) Jackson

4. DATE OF DEATH: (Month) 10 (Day) 29 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Colored	Married	12-17-04	50 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Emporia, Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Junius Wyche	Della Caine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	None	Deceased

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

017.2 IMMEDIATE CAUSE (A) Dense Miliary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cardiac Insufficiency

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 13, 1955, to Oct. 29, 1955, that I last saw the deceased alive on Oct. 29, 1955, and that death occurred at 6.00 P.M. from the causes and on the date stated above.

SIGNATURE I. F. Vestal, M.D. M.D. — **ADDRESS** (Street, city, town, state) Henryton, Md. — **DATE SIGNED** 10-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-4-55	Mt Calvary	Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
10-29-55	Albert R. Swanekamp	George S. Kelson	134 E. Calhoun St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09634

9628

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 5Y 3M 27 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY B
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 W. 14
STREET ADDRESS (If rural give location) 1308 Glyndon Avenue W.

3. NAME OF DECEASED: (Type or Print) (First) IRVIN (Middle) JOHN (Last) KNAPP

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 7/30/01

9. AGE last birthday: 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Broom shop

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin Benjamin Knapp

14. MOTHER'S MAIDEN NAME: Catherine Easter

15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.1 IMMEDIATE CAUSE (A) Gangrene of both legs — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis — 5 years

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with mental deficiency — Psychosis-5 Y M. D.- life

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/25, 1954 EST to 10/12, 1955, that I last saw the deceased alive on 10/12, 1955, and that death occurred at 7:05 AM, from the causes and on the date stated above.

SIGNATURE Wm. H. Sonnendeck M.D. ADDRESS Sykesville, Maryland DATE SIGNED 10/12/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-15-55 — NAME OF CEMETERY OR CREMATORY William Cook Inc — LOCATION (City, town, or county) 1317 St. Paul St. (State)

DATE REC'D BY LOCAL REGISTRAR 10-13-55 — REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR — ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09635

9529

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 4/30/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 806 S. Bond Street

3. NAME OF DECEASED: (First) Stanley (Middle) - (Last) KOPEC

4. DATE OF DEATH: (Month) October (Day) 11 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: February 8, 1876
9. AGE last birthday: 79 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: None -
11. BIRTHPLACE (State or foreign country): Poland (naturalized)
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Frank Kopec
14. MOTHER'S MAIDEN NAME: Mary - Unk -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 IMMEDIATE CAUSE	(A) Bronchopneumonia	4 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Generalized arteriosclerosis - more	than 3 yrs.
	DUE TO (C) —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction	more than 3 yrs.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 26 19 52 to Oct. 11 1955, that I last saw the deceased alive on Oct. 11, 1955, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. ADDRESS Sykesville, Maryland DATE SIGNED 10/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-17-55
NAME OF CEMETERY OR CREMATORY Springfield
LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 17, 1955
REGISTRAR'S SIGNATURE C. Harrington
24 FUNERAL DIRECTOR Wm. H. Haight
ADDRESS Sykesville, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09636

9630 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 23Y 6M 1D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 14 3V01-4
STREET ADDRESS (If rural give location) 3007 Overland Avenue

3. NAME OF DECEASED: (Type or Print) (First) Pauline (Middle) B. (Last) Korn

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 9 - 24 - 77

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Broghamer

14. MOTHER'S MAIDEN NAME: Mary Becker Enderman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unk

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 9047
(A) Septicemia due to decubitus ulcers — Weeks

ANTECEDENT CAUSE (B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Subcapital fracture of femur — 4 months
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia Paranoid Type — 23 years

19A. DATE OF OPERATION: 6-30-55
19B. MAJOR FINDINGS OF OPERATION: Subcapital fracture of femur-Well-leg splint
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ward
21C. WHERE DID INJURY OCCUR? (City or town) Sykesville (County) Carroll (State) Md

21D. TIME OF INJURY (Month) 6 (Day) 14 (Year) -55 (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☒
21F. HOW DID INJURY OCCUR? Pt. fell while going for supper

22. I hereby certify that I attended the deceased from 6-14-55, 19 , to 10-22-, 1955, that I last saw the deceased alive on 10-22-, 1955, and that death occurred at 4:55 PM, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M. D. ADDRESS Springfield State Hospital DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-25-55
NAME OF CEMETERY OR CREMATORY Parkwood Cem.
LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct. 23, 1955
REGISTRAR'S SIGNATURE C. Harry Weis
24. FUNERAL DIRECTOR Leonard J. Tuck 5305
ADDRESS Harford

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09637

9598 **CERTIFICATE OF DEATH** Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 1 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 Anchor St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural, give location) 4029 Wilkens Ave.,

3. NAME OF DECEASED: (Type or Print) (First) EDMUND (Middle) A. (Last) LEIDENROTH

4. DATE OF DEATH: (Month) Dec (Day) 15 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widower	Aug. 12, 1886	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Tool Keeper	Manufacturing	Md.	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
August F. Leidenroth	Catherina Nordhoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	217-22-2879	Mrs. Lawrence C. Card 121 Anchor St., Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval between onset and death)

163X
Immediate cause (a) Leiomyoma Lung — 3 mos.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Sept 16, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 15 1955, and that death occurred at 11:15 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

James J Monck M.D. Westminster Md 10/17/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-17-1955	Lorraine Park	Woodlawn, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
10-17-55	H. W. Redmond	G. Howard Strong 3207 W. North Ave.,

SMK

09638

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9631 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: Sykesville
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 7 months 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport 21X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Michael (Last) LisKey

4. DATE OF DEATH: (Month) 10 (Day) 23 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Sep. | 8. DATE OF BIRTH: 4/2/83 | 9. AGE last birthday 72 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Clinton Liskey
14. MOTHER'S MAIDEN NAME: Ida C. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 214-09-4533
17. INFORMANT & ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
023X
IMMEDIATE CAUSE (A) Chronic valvular disease (aortic valve stenosis) — INTERVAL BETWEEN ONSET AND DEATH: years
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Systemic Syphilis — years
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. G.B.S. Syphilis Neurosyphilis — years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2, 1955 to 10/23, 1955 that I last saw the deceased alive on 10/23, 1955, and that death occurred at 9:05 P.M., from the causes and on the date stated above.
SIGNATURE Geforde M. Gross, M.D. M.D. ADDRESS Sykesville, Md DATE SIGNED 10/24/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF Oct 28/55 | NAME OF CEMETERY OR CREMATORY Rose Hill | LOCATION (City, town, or county) (State) Hagerstown Md
DATE REC'D BY LOCAL REGISTRAR Oct. 24, 1955 | REGISTRAR'S SIGNATURE C. Harry Weed
24. FUNERAL DIRECTOR ADDRESS R K Hoffman Hagerstown Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09639

9632

CERTIFICATE OF DEATH

Reg. Dist. No. 54

1. PLACE OF DEATH: Rural Sykesville, Maryland
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1 Mo. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural: Sandy Spring, Maryland
STREET ADDRESS (If rural give location) 15X-21

3. NAME OF DECEASED: (Type or Print) Bessie Bruce Lockyer
4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 19 55

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Wid.
8. DATE OF BIRTH: 7-10-78
9. AGE last birthday: 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk -
10B. KIND OF BUSINESS OR INDUSTRY: Unk -
11. BIRTHPLACE (State or foreign country): U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Bruce
14. MOTHER'S MAIDEN NAME: Mary Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE: 023X
(A) Myocardial Insufficiency — days

ANTECEDENT CAUSE (B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO
(B) Generalized arteriosclerosis — years
DUE TO
(C) Systemic syphilis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with arteriosclerosis, with psychotic reaction — cerebral years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14, 19 55, to 10-19, 19 55, that I last saw the deceased alive on 10-19, 19 55, and that death occurred at 2:20 A M, from the causes and on the date stated above.

SIGNATURE Gertrude M. Gross, M.D. — ADDRESS M. D. Springfield State Hospital — DATE SIGNED 10-19-1955

Gertrude M. Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 10-21-55
NAME OF CEMETERY OR CREMATORY: Cedar Hill cemetery
LOCATION (City, town, or county) (State): Suitland Md.

DATE REC'D BY LOCAL REGISTRAR: Oct. 19, 1955
REGISTRAR'S SIGNATURE: C. Wm. Wilk
24. FUNERAL DIRECTOR: [illegible]
ADDRESS: [illegible]

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09640

9633

CERTIFICATE OF DEATH

Reg. Dist. No. 70

Item 7, Film G188 11-4-55 et

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rual
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Baltimore Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rual X
STREET ADDRESS (If rural give location) Old Baltimore Road

3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) ELSIE Myrtle Mann

4. DATE OF DEATH: (Month) (Day) (Year) Oct. 25 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: Dec. 8, 1884
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll County
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Arnold
14. MOTHER'S MAIDEN NAME: Ida Gamber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: James R. Mann, Westminster, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 422.2	(A) Pulmonary Fibrosis.	3 yrs.
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Myocarditis	5 yrs
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	abdominal adhesions	1½ yrs

19A. DATE OF OPERATION: June 13, 1954
19B. MAJOR FINDINGS OF OPERATION: Sub-acute appendix & abdominal adhesions
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc): none
21C. WHERE DID INJURY OCCUR? (City or town) none (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐: none
21F. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from Jan. 5, 1943, to Oct. 25, 1955, that I last saw the deceased alive on Oct. 25, 1955, and that death occurred at 8:30 P M, from the causes and on the date stated above.

SIGNATURE: J. D. Taylor M.D. ADDRESS: Reisterstown, Md. DATE SIGNED: 10-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Oct. 28.55
NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
LOCATION (City, town, or county) (State): Gamber, Carroll Co. Md.

DATE REC'D BY LOCAL REGISTRAR: 10-24-55
REGISTRAR'S SIGNATURE: Hazel Kuhn
24. FUNERAL DIRECTOR: J. E. Myers Jr.
ADDRESS: Westminster Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

9634

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 82-83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Mt. Airy
LENGTH OF STAY (In this place) 36 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Frederick
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Airy
STREET ADDRESS (If rural, give location) Hill St.

3. NAME OF DECEASED: (Type or Print) (First) BERTHA (Middle) EVANS (Last) MERRICK

4. DATE OF DEATH: (Month) 10/18/ (Day) (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 12-23-1890

9. AGE Last birthday: 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rickard Evans

14. MOTHER'S MAIDEN NAME: Elizabeth Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs. Nicholas Knott, Hillsboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO: Crushing injury of chest with rupture of heart

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street

21c. (City or town) Carroll (County) (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/18/55 10:15 A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Driver - lost control of car

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R B Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 10/18/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 10-21-1955

NAME OF CEMETERY OR CREMATORY Greenmount

LOCATION (City, town, or county) (State) Queen Anne Co., Md.

DATE REC'D BY LOCAL REG. 10-20-55

REGISTRAR'S SIGNATURE Robert R. Hewitt

24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09642

9635 CERTIFICATE OF DEATH Reg. Dist. No. 14

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 419 Brown Ave

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) E (Last) Miller

4. DATE OF DEATH (Month) 11 (Day) 1 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: Sept 3 1887
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months IF UNDER 24 HRS.: Days Hours Min. 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): not known
10B. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): not known
12. CITIZEN OF WHAT COUNTRY? Unk

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) yes. (If Yes, give war or dates of service) 1907 to 1911 Marine Corps.
16. SOCIAL SECURITY NO. 705-10-7621
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) S. Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days +

ANTECEDENT CAUSE (B) DUE TO: Unknown cause

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile arteriosclerosis.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) No injury reported.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-13, 1955 to 11-1, 1955 that I last saw the deceased alive on 9-30-, 1955, and that death occurred at 6:15 A M, from the causes and on the date stated above.
SIGNATURE Walter H Immenschuh M.D. ADDRESS Springfield State Hospital DATE SIGNED 11/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 11-3-55
NAME OF CEMETERY OR CREMATORY United Brethren Church
LOCATION (City, town, or county) Thurmont (State) Md

DATE REC'D BY LOCAL REGISTRAR Nov. 2, 1955
REGISTRAR'S SIGNATURE C. Harry [illegible]
24. FUNERAL DIRECTOR J. E. Eyler & Son
ADDRESS Thurmont

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09643

9636

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
LENGTH OF STAY (in this place) 9 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Long View Nurs Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) VIRGIE (Middle) V (Last) NAYLOR

4. DATE OF DEATH (Month) Oct (Day) 21 (Year) 1955

5. SEX F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH: Feb 22-1888
9. AGE last birthday 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H W
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H Bosley
14. MOTHER'S MAIDEN NAME: Mary E Cullison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: J H Naylor - 4214 Fallo Rd - Balto Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE	(A) Diabetic Gangrene Leg	1 Months
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Diabetes	
	DUE TO (C) Cerebral Hemorrhage	4 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20/, 1955, to 10/21, 1955, that I last saw the deceased alive on 10/21, 1955, and that death occurred at 7P. M, from the causes and on the date stated above.

SIGNATURE W H Foard M. D.
ADDRESS Manchester, Md
DATE SIGNED 10/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Oct 24/55
NAME OF CEMETERY OR CREMATORY Mt Zion
LOCATION (City, town, or county) Balto Co (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct 25 - 55
REGISTRAR'S SIGNATURE Mrs. Wm. Denner
24. FUNERAL DIRECTOR Eldw Tipton
ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9637

CERTIFICATE OF DEATH

09644

Reg. Dist. No. ...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ykesville
LENGTH OF STAY (in this place) 4y-11m-7d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 6, Md. 03X-d
STREET ADDRESS (If rural give location) 6014 Shady Lane, ✓

3. NAME OF DECEASED: (Type or Print) (First) Grace ~~Viona~~ (Middle) Viona (Last) Pscherer

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 7 - 20 - 95

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Rabold

14. MOTHER'S MAIDEN NAME: Anna Pursell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
203X IMMEDIATE CAUSE	(A) Arteriosclerotic heart dis	years
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Anemia	years
	DUE TO (C) Multiple myeloma	years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	involutional psychosis depressed type with some paranoid features	5 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14- , 1955, to 10-22- , 1955, that I last saw the deceased alive on 10-21- 19 55, and that death occurred at 8:15 AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustkaus M.D. ADDRESS M. D. Springfield State Hospital DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF OCT 24-55 | NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | LOCATION (City, town, or county) (State) 4400 BELAIR RD MD

DATE REC'D BY LOCAL REGISTRAR 10/25/55 | REGISTRAR'S SIGNATURE C. W. Hedrick

24. FUNERAL DIRECTOR Doppel Bros ADDRESS 7110 Belair Rd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9638

CERTIFICATE OF DEATH

09645

Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Henryton
LENGTH OF STAY (in this place): 132 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 819 West Street

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Benson (Last) Rawlings

4. DATE OF DEATH: (Month) 10 (Day) 2 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 4-12-1912

9. AGE Last birthday: 43 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Contractors

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Rawlings, Jr.

14. MOTHER'S MAIDEN NAME: Mary Calvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-05-8824

17. INFORMANT & ADDRESS: Joseph B. Rawlings - 819 West Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 002X Hypertensive Cardiovascular Disease

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Minimal bilateral pulmonary tuberculosis

DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-23-, 1955, to 10-2-, 1955, that I last saw the deceased alive on 10-2-, 1955, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): T. F. Postal M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: 10-2-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 6, 1955 — NAME OF CEMETERY OR CREMATORY: Chews Chapel — LOCATION (City, town, or county) (State): Owensville, Maryland

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: William Reese, II — ADDRESS: 108 Washington St. Annapolis, Md.

VS. A15

09646
75

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9639

CERTIFICATE OF DEATH

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Manchester

LENGTH OF STAY (in this place): 2 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester X

STREET ADDRESS (If rural give location): Route 1

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	Melba	McAdow	Raycob	Oct	25	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	M	Nov 11 1900	54 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frank McAdow	Grace Stella Snyder

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	218-10-0156	Frederick I Raycob Sr Manchester Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) 148X Lympho - epithelioma — Interval Between Onset And Death: 1yr

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) — DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/29 ....., 1954, to Oct 25 ....., 1955, that I last saw the deceased alive on Oct 24 ....., 1955, and that death occurred at 4:30 PM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W H Howard	M.D.	Manchester, Md.	10/25/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 28 1955	Manchester Luth Cem.	Manchester Md

DATE REC'D BY LOCAL REGISTRAR: 10-27-55 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Wm Berryman & Sons Reisterstown Md

Oct, 30-55 Mrs. Mrs Dennis

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09647

9640 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 9 mos. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton
STREET ADDRESS (If rural give location) 11264 Old Bladensburg Road

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Mansfield (Last) REED

4. DATE OF DEATH: (Month) 10 (Day) 4 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH: 2/12/70 | 9. AGE last birthday 85 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Nat. Zoo. Park - Govt. Service
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bushrod Reed
14. MOTHER'S MAIDEN NAME: Catherine Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service) -
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332.X
IMMEDIATE CAUSE (A) Cerebral Thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo. 5 days
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis — years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 1½ years

19A. DATE OF OPERATION. | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29, 1955, to 10/4, 1955 that I last saw the deceased alive on 10/3, 1955, and that death occurred at 11:00 AM EST, from the causes and on the date stated above.
SIGNATURE Edmund Leuthauer M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Remarl | DATE THEREOF 10/4/55 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) Silver Spring, Md

DATE REC'D BY LOCAL REGISTRAR Oct. 4, 1955 | REGISTRAR'S SIGNATURE C. Harry Tilson | 24. FUNERAL DIRECTOR Warner E. Pumphrey | ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09648

9641

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (In this place) 3Y 6M 12 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Yo - 4.
STREET ADDRESS (If rural give location) 2421 Maryland Avenue

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) FREDERICK (Last) SCHAEFER

4. DATE OF DEATH: (Month) 10 (Day) 30 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: 7/13/76
9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard
10B. KIND OF BUSINESS OR INDUSTRY: Bank - Union Trust
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Schaefer
14. MOTHER'S MAIDEN NAME: Mary — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Myocardial infarction — days
DUE TO
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic heart disease — years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma of bladder — years
Cr.Br.Syndrome assoc. with senile brain disease 3 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/55, 19 , to 10/30, 19 55 that I last saw the deceased alive on 10/29, 19 55, and that death occurred at 6:15 A M, from the causes and on the date stated above.

SIGNATURE Edmund Sutton M. D.
ADDRESS Sykesville, Maryland
DATE SIGNED 10/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF Nov-3-55
NAME OF CEMETERY OR CREMATORY Balto.
LOCATION (City, town, or county) (State) Balto.

DATE REC'D BY LOCAL REGISTRAR Oct. 31, 1955
REGISTRAR'S SIGNATURE C. Harry Zimmerman
24. FUNERAL DIRECTOR Cook Sons
ADDRESS 1319 Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9642 CERTIFICATE OF DEATH

09649

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural give location) R.D. 2

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) T. W. (Last) SHERFEY

4. DATE OF DEATH: (Month) Oct. (Day) 10 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 12. 1880

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Lab. Labour

10b. KIND OF BUSINESS OR INDUSTRY: Lumber yard

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Sherfey

14. MOTHER'S MAIDEN NAME: Lavinia Eyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-05-1705

17. INFORMANT & ADDRESS: Mrs Anna Forrest R.D. 2 Westminster Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 4-4-2 X (a) acute Cardiac dilatation — Interval Between Onset And Death: 24 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Cardio Renal disease — 1 yr

DUE TO (c) Arteria Sclerosis — 1 yr

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-9-, 1955, to 10-10-, 1955, that I last saw the deceased alive on 10-9-, 1955, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas R. Foutz M.D. ADDRESS Westminster Md. DATE SIGNED 10-11-55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Oct. 14. 1955 NAME OF CEMETERY OR CREMATORY Westminster Cemetery LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-11-55 REGISTRAR'S SIGNATURE Harvey Butler 24. FUNERAL DIRECTOR Frankenfield Son Westminster ADDRESS Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09650

9543 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 4/7/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED: (Type or Print) (First) Carroll (Middle) Austin (Last) SHREVE

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Sept. 27, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Work.

10B. KIND OF BUSINESS OR INDUSTRY: Work.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Daniel T. Shreve

14. MOTHER'S MAIDEN NAME: Margaret Ellen Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn. If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 491X (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) senility — 7 years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — 7 years

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from July 16, 1954, to Oct. 9, 1955, that I last saw the deceased alive on Oct. 8, 1955, and that death occurred at 12:30 M, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. M.D.

ADDRESS Sykesville, Maryland

DATE SIGNED Oct. 9, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 10/10/55

NAME OF CEMETERY OR CREMATORY St Mary's

LOCATION (City, town, or county) (State) Baltimore Woods Md

DATE REC'D BY LOCAL REGISTRAR Oct. 9, 1955

REGISTRAR'S SIGNATURE C. Harry Thaw

24. FUNERAL DIRECTOR (Signature and ADDRESS) William B. Dallam Sons Inc Sykesville Md

9614

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09651 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home - RFD 1, Sykesville

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sykesville Rural X
STREET ADDRESS RFD 1 (If rural, give location) Sykesville 1

3. NAME OF DECEASED: (Type or Print) (First) Vernon (Middle) Lee (Last) Sibert

4. DATE OF DEATH (Month) October (Day) 27 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: Mar - 1904

9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Weaver

10b. KIND OF BUSINESS OR INDUSTRY: Woolen Mill

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Percy L. Seibert

14. MOTHER'S MAIDEN NAME: Elizabeth Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: Unk -

17. INFORMANT & ADDRESS: Mrs. Emory Sime - Sykesville Rt. 91

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

490X
Immediate cause (a) Lobar Pneumonia, middle and lower lobes right lung.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: **19b. MAJOR FINDING OF OPERATION:** **20. AUTOPSY?** Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. **21b. PLACE** (Home, farm, factory, OF street, office bldg., etc., INJURY **21c.** (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. **21e. INJURY OCCURRED** While at work ☐ Not while at work ☐ **21f. HOW DID INJURY OCCUR?**

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl F. Green M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 10/28/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-31-55	Mt. Union	Taneytown, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 28, 1955	C. Harry Fiser	Comfort Funeral Home	Uniontown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09652

9545

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) EDWARD (Last) SMITH

4. DATE OF DEATH: (Month) Oct (Day) 18 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Feb 6 1876

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Smith

14. MOTHER'S MAIDEN NAME: Clara C Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: George B Smith New Windsor Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 44 2X

(A) Chronic Myocarditis

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteri Sclerosis with High BP

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: months.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1 ., 19 55, to Oct. 18., 19 55, that I last saw the deceased alive on Oct 18 ., 19 55, and that death occurred at 5:40 PM, from the causes and on the date stated above.

SIGNATURE J. N Legg M. D. ADDRESS Union Bridge DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried

DATE THEREOF Oct 21-1955

NAME OF CEMETERY OR CREMATORY Winters

LOCATION (City, town, or county) (State) Carroll Co, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct 19 55

REGISTRAR'S SIGNATURE Carrie L Bynedict

24. FUNERAL DIRECTOR ADDRESS D W Hunter & Sons, New Windsor, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

OCT 21 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09544

9646 CERTIFICATE OF DEATH Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Star Route

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount
STREET ADDRESS (If rural give location) Star Route

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) W. (Last) SMITH

4. DATE OF DEATH: (Month) Oct. (Day) 5 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: April 3, 1888

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Head Gardner

10B. KIND OF BUSINESS OR INDUSTRY: Gardening

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Cromlett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-05-2017

17. INFORMANT & ADDRESS: Mr. Clyde E. Stouffer-Star Route, Greenmount Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

14 K

IMMEDIATE CAUSE (A) Carcinoma of Larynx (Metastatic) — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSE (S' DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Carcinoma of Lip — 5 yrs.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 55 to Oct 5 55, that I last saw the deceased alive on Oct. 5 55, and that death occurred at 2 P M. from the causes and on the date stated above.

SIGNATURE M. C. Partridge M. D. ADDRESS Hampstead, Md. DATE SIGNED 10-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 10/8/55

NAME OF CEMETERY OR CREMATORY: Good Shepherd

LOCATION (City, town, or county) (State): Howard Co., Md.

DATE REC'D BY LOCAL REGISTRAR: 10-6-55

REGISTRAR'S SIGNATURE: C. L. Hoover

24. FUNERAL DIRECTOR: Wm. J. Tichenor & Sons

ADDRESS: Md. Baltimore 17

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09653

9647

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural Union Bridge
LENGTH OF STAY (in this place): 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 90 Rowe Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Taneytown X
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	M.	Spangler	October 23, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	Widow	July 8, 1870	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Penna.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ephriam F. Herr	Mary J. Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	Mrs. Dovie Miller, Gettysburg, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1420.0 Immediate cause (a) Arteriosclerosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan., 19 55, to Oct 22, 19 55, that I last saw the deceased alive on Oct 23, 19 55, and that death occurred at 5 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. H Legg	M D	Union Bridge	10-25-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 26 1955	Lutheran Cemetery	Harney, Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Oct 26, 1955	Leslie L. Repp	C.O.Fuss & Son, Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9648

CERTIFICATE OF DEATH

09654

Reg. Dist. No. 87

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: County Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Union Bridge | LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Bridge
STREET ADDRESS (If rural give location): Broadway

3. NAME OF DECEASED: (Type or Print) (First) ESTHER (Middle) PHILENA (Last) STITELY

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 19-55

5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single | 8. DATE OF BIRTH: Aug. 8-1865 | 9. AGE last birthday: 90 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housekeeper | 10b. KIND OF BUSINESS OR INDUSTRY: at home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jacob Stitely | 14. MOTHER'S MAIDEN NAME: Emma E. Repp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Carroll E. Stitely Westminster, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

450.0
Immediate cause (a) DUE TO: Cerebral Sclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO:
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED White at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 21, 1955, to Oct. 22, 1955, that I last saw the deceased alive on Oct. 22, 1955, and that death occurred at Oct. 23-55-6 9:30 m., from the causes and on the date stated above.

SIGNATURE: J. H. Legg (Degree or title: MD) ADDRESS: Union Bridge Md DATE SIGNED: 10-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE THEREOF: 10-26-55 | NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery | LOCATION (City, town, or county): Littlestown | (State): Pa.

DATE REC'D BY LOCAL REGISTRAR: Oct. 25, 1955 | REGISTRAR'S SIGNATURE: Leslie Repp

24. FUNERAL DIRECTOR: D. D. Hauver & Sons | ADDRESS: Union Bridge, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09655

9649 CERTIFICATE OF DEATH Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 36 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural give location) 1429 Webb Court

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) (Last) Sykes
4. DATE OF DEATH: (Month) 10- (Day) 5- (Year) 1955

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 7-5-1897
9. AGE Last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elizabeth City, N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Silas Sykes
14. MOTHER'S MAIDEN NAME: Mary Jane Bennett

15 WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Walter Sykes - 1429 Webb Court

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
002X
Immediate cause (a) Far advanced bilateral cavitary tuberculosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30- ,1955 , to 10-5- , 1955, that I last saw the deceased alive on 10-5- , 1955., and that death occurred at 6:30 A.M. , from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
I. F. Holstead M.D

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 10-10-55
NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
LOCATION (City, town, or county) (State) Balto. Md.
DATE REC'D BY LOCAL REGISTRAR 10-5-55
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Adolphus Halstead
ADDRESS 2118 Hill ave.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09656

9659

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 19y 11m 7days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland CIC 2-3
STREET ADDRESS (If rural give location) 711 Kenwood

3. NAME OF DECEASED: (Type or Print) (First) Edith (Middle) Lee (Last) Tansill

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: ? ? 1896

9. AGE last birthday 59 ? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Hipsley

14. MOTHER'S MAIDEN NAME. Alice Fillers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic heart disease — several yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Paranoid State. — 21 y +

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955, to October 22, 1955, that I last saw the deceased alive on October 22, 1955, and that death occurred at 12:35 p.m., from the causes and on the date stated above.

SIGNATURE Mathew H Sonnenschein M. D. ADDRESS Springfield State Hospital DATE SIGNED 10/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-25-55 — NAME OF CEMETERY OR CREMATORY Hill Crest — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Oct 23, 1955 — REGISTRAR'S SIGNATURE C. Harry Wiley

24. FUNERAL DIRECTOR, ADDRESS James Harper - Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9651

CERTIFICATE OF DEATH

09657

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (In this place) 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 7
STREET ADDRESS (If rural give location) 5007 Belleville Avenue

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) MERLE (Last) TOTTY

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 195

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Sep.

8. DATE OF BIRTH: 5-4-80

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Groc. Store Manager

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland (Baltimore)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Totty

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-03-1540

17. INFORMANT & ADDRESS: Mrs Harry M. Totty 5007 Belleville Av Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 002X
(A) Bronchopneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO
(B) Tuberculosis of lung, far-advanced — 6 months
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CPS associated with senile brain disease, with psychotic reaction, plus, pulm. tbc. — 5 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-19, 1955, to 10-19, 1955, that I last saw the deceased alive on 10-18-55, 19 and that death occurred at 3:40AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustman M.D. ADDRESS Springfield State Hospital DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Oct. 22 1955
NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
LOCATION (City, town, or county) (State): Baltimore, Maryland.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Miles L Mullan ADDRESS: 4510 Liberty Heights Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09658

9652

CERTIFICATE OF DEATH

Reg. Dist. No. ...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 27Y-2M-21D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V014
STREET ADDRESS (If rural give location) 709 N. Monroe Street

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) (Last) Townsend

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 7 - 8 - 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packer

10B. KIND OF BUSINESS OR INDUSTRY: meat packing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Townsend

14. MOTHER'S MAIDEN NAME: Annie E. Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unkn (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 581.1

(A) Hemorrhages & Varices

ANTECEDENT CAUSE (B)

DUE TO (B) Cirrhosis of the Liver (Laennec). Liver cancel type.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: Hemorrhages sudden.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Alcoholic hallucinosis — 27 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2-..., 1955, to 10-22-..., 1955, that I last saw the deceased alive on 10-21-55, and that death occurred at 8:20 AM, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M.D. — ADDRESS M.D. Springfield State Hospital — DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-25-55 — NAME OF CEMETERY OR CREMATORY Mt Olivet Cem — LOCATION (City, town, or county) (State) Frederick Md

DATE REC'D BY LOCAL REGISTRAR 10/24/55 — REGISTRAR'S SIGNATURE Alan Hedrick

24. FUNERAL DIRECTOR Thomas J Kenny Inc — ADDRESS 1600 Hollins St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09659

9653 **CERTIFICATE OF DEATH** Reg. Dist. No. 7

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 6 Y, 6 M, 27 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) WALTERS

4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 2/11/80

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevedore

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: Martin Walters

14. MOTHER'S MAIDEN NAME: Julie Luziane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS. Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.1

IMMEDIATE CAUSE (A) Septicemia — days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Gangrene of the extremity — months

DUE TO (C) Generalized arteriosclerosis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis — 8 years

19A. DATE OF OPERATION: 10/18/55

19B. MAJOR FINDINGS OF OPERATION: Gangrene of lower left extremity up to knee

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21, 1955, to 10/28, 1955, that I last saw the deceased alive on 10/28, 1955, and that death occurred at 9:25 AM, EST from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 11/1/55 | NAME OF CEMETERY OR CREMATORY Sacred Heart | LOCATION (City, town, or county) (State) Dennard Rte Rd

DATE REC'D BY LOCAL REGISTRAR 10/31/55 | REGISTRAR'S SIGNATURE C. H. French | 24. FUNERAL DIRECTOR J. Fahey & Sons | ADDRESS 1318 Light

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09660

9654 CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville; MARYLAND LENGTH OF STAY (in this place) since 3-1-33; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Cumberland; STREET ADDRESS (If rural give location) Elk st.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ellen (Last) Welsh

4. DATE OF DEATH: (Month) October (Day) 7 (Year) 1955

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: January 30, 1877

9. AGE last birthday: 77 yrs; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Isreal Twigg

14. MOTHER'S MAIDEN NAME: Nancy Ann Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unk.

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 1st

ANTECEDENT CAUSE (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) DUE TO Paget's disease of right breast — INTERVAL BETWEEN ONSET AND DEATH: more than 12 years

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Involutional Melancholia — more than 20 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-27, 1948, to Oct. 7, 1955, that I last saw the deceased alive on Oct. 7, 1955, and that death occurred at 0:30 P.M., from the causes and on the date stated above.

SIGNATURE Marian Nadolski M. D. ADDRESS Sykesville, Md. DATE SIGNED 10-7-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial; DATE THEREOF 10-11-55; NAME OF CEMETERY OR CREMATORY Cumberland; LOCATION (City, town, or county) (State) Allegany Co. Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 8, 1955; REGISTRAR'S SIGNATURE C. Harry Taylor; 24. FUNERAL DIRECTOR Stazzelli Funeral Home; ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

9655 — 09661

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH— COUNTY: Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Westminster
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED— STATE: Maryland COUNTY: Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Westminster
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) EDWARD (Middle) (Last) WILLIAMS

4. DATE OF DEATH (Month) OCT. (Day) 24, (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 9-3-1881
9. AGE last birthday: 74 yrs. If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm laborer
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William R. Williams
14. MOTHER'S MAIDEN NAME: Milesann Turfel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: Ella M. Fossett, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 420.1
Immediate cause (a) Acute Coronary thrombosis
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (Found dead in corn field)—
(c)

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/24, 1955, to 10/24, 1955, that I did not see the deceased alive on —, 19...., and that death occurred at 10 A.M. m., from the causes and on the date stated above.

SIGNATURE: J. Luther Bare (Degree or title) M.D. Deputy medical Examiner ADDRESS: Westminster Md DATE SIGNED: 10/24/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE: 10-27-1955
NAME OF CEMETERY OR CREMATORY: Deer Park
LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REG.: 10-27-1955
REGISTRAR'S SIGNATURE: E. M. Farver
24. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09662

9656 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 10 month 3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 3V01-4
STREET ADDRESS (If rural give location) 1110 N. Kenwood Avenue

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) (Last) WILSON

4. DATE OF DEATH. (Month) 10- (Day) 20 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: 8-28-86
9. AGE last birthday 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Unk-
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wilson
14. MOTHER'S MAIDEN NAME. Mary Ellen Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk-
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

IMMEDIATE CAUSE (A) Myocardial infarction — hours

ANTECEDENT CAUSE (S) DUE TO (B) Coronary occlusion — days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic heart disease — years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with circulatory disturbance, arth cere. arteriosclerosis, without quali- — Years

fying phrase.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4-55, 19 , to 10-20..., 19.55, that I last saw the deceased alive on ...10-20 .. , 19 55, and that death occurred at 9:45 AM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeld M. D. ADDRESS Springfield State Hosp. DATE SIGNED 10-20-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-24-55
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 21, 1955
REGISTRAR'S SIGNATURE C. Henry Akers
24. FUNERAL DIRECTOR W. E. Cook, Inc.
ADDRESS 1217 E. Fairmount Ave. Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9657

Reg. Dist. No. 09663 34

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 9y 8mo 26 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) unknown √

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) (Last) WOODEN

4. DATE OF DEATH: (Month) (Day) (Year) 10 - 1 - 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 6-1-65

9. AGE last birthday: #90 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Enos Wooden

14. MOTHER'S MAIDEN NAME: Mary E. Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNK. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Mrs. Carl Northard (daughter)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis secondary to Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated arteriosclerosis — years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4 ..., 1946, to 10-1, 1955, that I last saw the deceased alive on 10-1-, 1955, and that death occurred at 6:45 A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital. DATE SIGNED 10/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-4-55
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 7, 1955
REGISTRAR'S SIGNATURE C. Harry Eiler
24. FUNERAL DIRECTOR Wm Cook, Jr. ADDRESS 1212 N. Fulton Ave. Balto. Md.

RECEIVED
OCT 5 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09664

9658

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hampstead Rural
LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 /

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead - Rural X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) NATHANIEL (Middle) B (Last) WOODY

4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Feb 22 1882

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner

10B. KIND OF BUSINESS OR INDUSTRY: Farm.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gilbert Woody

14. MOTHER'S MAIDEN NAME: Fannie Saylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs N B Woody - Hampstead Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260X IMMEDIATE CAUSE	(A) Cerebral Hemorrhage	1 hr
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerotic Heart Disease	5 yrs
	DUE TO (C) Diabetes	3 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1955, to Oct 10, 1955, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 2 A M, from the causes and on the date stated above.

SIGNATURE W N Hoard ADDRESS M. D. Manchester, Md DATE SIGNED 10-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 12 55	Greenmount	Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/10/55	Henry J Rees	Edw C Tipton	Hampstead Md

RECEIVED
OCT 13 1965
BUREAU V. S.